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ABSTRACT

This article contributes empirical findings and sociological theoretical perspectives to discussions of the role of community lay health workers, including in improving the health of individuals and communities. We focus on the role of the Health Trainer (HT), at its inception described as one of the most innovative developments in UK Public Health policy. As lay health workers, HTs are tasked with reducing health inequalities in disadvantaged communities by supporting clients to engage in healthier lifestyles. HTs are currently sociologically under-researched, particularly in relation to occupational identity work, and the boundary work undertaken inter-occupationally with other health workers. To address this research lacuna, a qualitative study was undertaken with 25 HTs based in the Midlands region of the UK. In theorising our findings, we employ a novel combination of symbolic interactionist conceptualisation of 1) identity work, and of 2) boundary work. The article advances knowledge in the field of health and exercise by investigating and theorising how HTs construct, work at, manage, and communicate about professional/occupational boundaries, in order to provide personalised support to their clients in achieving and sustaining healthy behaviour change within the constraints of clients' lifeworlds.

The introduction of Health Trainers (HTs)[1] in the United Kingdom (UK) in 2004 was described as one of the most innovative developments in UK public health policy (South, Woodward, and Lowcock 2007). HTs constitute an occupational group working within the Public Health sector, with the role transferred from the National Health Service (NHS) to local government in 2012. The purpose of the HT role is to 'promote healthy living and help people make healthier lifestyle choices' (UK National Careers Service 2018), and, ambitiously, to reduce health inequalities in local communities by supporting clients in developing and sustaining healthier lifestyles, for example via smoking cessation, reducing alcohol intake, increasing exercise and physical activity levels, and having healthier diets. We provide further information about the political and policy background below. Importantly, HTs are responsible for referring, or signposting their clients to other specialist health services and professionals for issues deemed beyond their jurisdiction. This form of occupational 'boundary work' (Gieryn 1983) was found to figure prominently in HTs' identity talk, and is not only of sociological interest in operationalising and elaborating the conceptualisation of occupational boundary work and maintenance, but also in considering the impact upon HTs' clients and how they are supported in healthy behaviour change, as we discuss below.

As Lamont and Molnár (2002) note, the concept of boundaries has been at the centre of influential research agendas. These authors portray 'boundary work' as work undertaken by individuals and groups as they mobilise typifications of similarities and differences, and use these to define who and what they are. Despite a considerable research corpus on boundary work in formal medical settings (e.g. Allen 2001; Cregård 2018; Timmons and Tanner 2004), the everyday occupational identities and lifeworlds of HTs as lay health workers in less formal settings remain relatively under-researched (Rahman and Wills 2013). Such lay roles and programmes are important as they constitute bridges between disadvantaged populations and healthcare systems and are increasingly being implemented in Western industrialised countries (Williams et al. 2016; Henderson et al. 2018). Many lay health workers work alongside National Health Service (NHS) occupations and services, but the uncertainty surrounding their roles and relationship to other health professionals has been signalled as problematic (Kennedy, Milton, and Bundred 2008). HTs' occupational identities and relationships with other health professionals are sociologically interesting, not least because the boundary work in which they engage has implications for their clients and communities, and in general remains under-researched. Furthermore, as Brown (2015) notes, the concept of 'identity work' is often employed, but only rarely explored systematically and empirically.

To address the research lacuna, we undertook a qualitative research project with the aim of investigating the occupational experiences of 25 HTs working in the Midlands region of the UK. To contextualise our key findings, we first provide background context regarding the lay HT role in the UK healthcare system, before portraying our theoretical perspective of symbolic interactionism, together with conceptualisations of identity and identity work (Allen-Collinson 2006, 2011; Beech, Gillmore, and Hibbert 2016; Perinbanayagam 2000; Snow and Anderson 1995, Allen-Collinson et al. 2018), and of boundary work (Gieryn 1983; Lamont and Molnár 2002); an innovative conceptual combination. The research project is then described, before presenting salient findings cohering around the identity-related themes of HTs' i) vocabularic identification, ii) associative identification, and iii) boundary work with other health professions. Our purpose is to contribute to research on processes of occupational identity work (e.g. Down and Reveley 2009; Watson 2008) and boundary work in health-related occupations, using HTs to illustrate these processes at work 'on-the-ground'.

Background

During the past 30 years, a key target of UK government policy has been to reduce substantial health inequalities between those living in the most disadvantaged areas of the country and those elsewhere (Trayers and Lawlor 2007). The role of lay workers in improving health has become increasingly recognised in research and policy (White, Woodward, and South 2013), and HTs are part of this growing workforce. As noted above, the introduction of the HT initiative in the UK in 2004 was regarded as one of the most innovative and interesting developments seen in Public Health policy (Department of Health 2004). First proposed in the government White Paper, *Choosing Health*, the initiative aimed to reduce health (and disease) inequalities and improve the health behaviour of those living in the most socially-deprived areas (Trayers and Lawlor 2007). Specifically, HTs were tasked with the provision of health-related information and support regarding issues such as smoking cessation, improving diet, reducing alcohol intake, increasing healthy physical activity, and addressing mental wellbeing issues (White, Woodward, and South 2013). Trained and equipped to provide basic health advice, HTs also provide an important point of referral to other specialist healthcare services. In 2005, the first HT teams were deployed in 12 Primary Care Trusts (PCTs). Subsequently, with widespread reforms to the English health system, responsibility for HTs transferred to the Public Health Directorate of local authorities. As part of a growing focus on the wider determinants of health, community development and the expansion of the Public Health workforce, it was envisaged that HTs would eventually become the fundamental building blocks for health improvement in 'deprived' communities (Department of Health (2004).

The HT role is thus considered important in actively supporting healthier lifestyle choices (UK National Careers Service 2018), including via exercise and physical activity programmes to which individuals can be referred or self-refer (Allen-Collinson 2018). HTs enter the job from a wide variety of social and occupational backgrounds, ranging from graduates seeking entry-level jobs, to older adults post-retirement. Whilst some HTs arrive in post with qualifications directly germane to their role (e.g. in exercise and/or physical activity, nutrition, weight management), most do not. Community embeddedness constitutes a major aspect of the HT role, requiring knowledge of, and sensitivity toward the local community's particular health needs, and the ability to work in partnership with a gamut of professionals germane to health work, such as General Practitioners (GPs) and exercise professionals. Typically, clients to whom HTs offer support may be identified by existing community and/or support groups, through referral by a health professional, or via self-referral (NHS Health Careers 2018).

The wide range of roles undertaken by HTs appears to be a salient feature of their working-lives, as is the generic nature of the job description. These factors can create complexities in operationalising the role and forging a distinctive occupational identity. Whilst the multi-disciplinary research team commenced the study with a theoretically open perspective, a symbolic interactionist perspective was subsequently found highly applicable in analysing identity and identity work (Allen-Collinson 2006, 2007; Snow and Anderson 1995) aspects. Commensurate with an interactionist schema, HTs' identity was found to be relational to other health workers, such as General Practitioners (GPs), exercise professionals, dieticians, and mental health workers. The nature and conceptualisations of identity and identity work, including in relation to health identities, are complex and multi-faceted (Beech, Gillmore, and Hibbert 2016; Lee and Lin 2011; Taylor 2005; Edmonds 2019), and there have been calls for in-depth qualitative research to bring to life and illustrate the theoretical processes at work (Down and Reveley 2009; Watson 2008). It is to that call we respond in this article. First, symbolic interactionist perspectives on identity and identity work are delineated, as these subsequently frame the findings presented below.

Symbolic interactionism and identity work

Given our interest in occupational identity and processes of identity work, symbolic interactionist conceptualisations of self and identity as malleable, relational and ongoing processes (Blumer 1969; Mead 2015/1934) are apposite, as the self is theorised as a *process* emergent in interactional encounters. Cooley (1983) conceptualised the self as having a dual aspect, a 'looking-glass self' with both a personal 'I' (the viewer) and a social 'me' (the viewed); the latter being highly cognisant of the social expectations and evaluations of others, both 'significant others' and the 'generalised other' (the cultural norms and values prevailing in the wider societal or organisational context). Subsequent interactionist theorists have drawn on the I/me distinction to analyse how social actors hold both personal and social identities (discussed below), and undertake identity work to establish, maintain or restore a coherent, consistent sense of identity, but also sometimes to 'engage in "self-questioning" rather than "self-affirming" identity work' (Beech, Gillmore, and Hibbert 2016: 507). As Hughes, Hockey, and Greg Berry (2019) also note, the power dimension is important in interactional encounters, as we compare ourselves to others in order to gain a sense of how much power or competence we hold in relation to others.

'Identity work' is the work undertaken by social actors in creating, maintaining, refining, and sometimes reworking and recreating identities, and has been studied in-depth from a symbolic interactionist perspective. As Stets and Burke (2003) note, for interactionists the overall self is organised into multiple parts or identities, each tied to aspects of the social structure. So, for example, a person may have an identity as a parent, a work colleague, a sister, a neighbour, and so on, and all these identities require ongoing 'work' in interactional encounters to present oneself convincingly as parent, sister, colleague, and so forth. Sveningsson and Alvesson (2003, 1165) thus describe identity work as the work in which people engage to form, repair, maintain, strengthen or

revise 'the constructions that are productive of a sense of coherence and distinctiveness'. Snow and Anderson (1995) have been pivotal in defining and refining the notion of identity work, seeking to identify its constituent elements, which for them comprise a number of complementary activities:

> '(a) procurement or arrangement of physical settings and props (b) cosmetic face work or the arrangement of personal appearance (c) selective association with other individuals and groups (d) verbal construction and assertion of personal identities.' (1995, 241)

Perinbanayagam (2000) subsequently adapted Snow and Anderson's framework, to reformulate identity work as comprising three forms of identification: *materialistic* (physical settings and personal appearance combined), *associative*, and *vocabularic*. These components of identity work have been explored in relation to various occupations and social groups, such as homeless people (Snow and Anderson 1995), occupational and student groups within academia (Allen-Collinson 2006; Allen-Collinson and Brown 2012), private military contractors (Higate 2012), retired military personnel (Williams et al. 2018), and recreational runners (Allen-Collinson and Hockey 2007), to give various examples. Of further relevance, Snow and Anderson (1995, 240) make a useful distinction between *social identities* (those that social actors attribute to others) and *personal identities* (those we self-attribute). These authors argue that social identities are not self-designations but imputations based primarily on information gleaned on the basis of appearance, behaviour, and also spatio-temporal location. Personal identities are those self-designations and self-attributions asserted or brought into play during social interaction. Social and personal identities are analytically distinct, therefore, and may be held in tension, and subject to intense contestation (Allen-Collinson 2011). Indeed, some of the HTs interviewed self-described their personal identities as professional healthcare workers, whilst noting how they felt cast by other health professionals as 'unskilled', 'unqualified', '*just* lay' workers. As Williams et al. (2016) have noted, the incorporation of HTs into the public health infrastructure in England has not proceeded without considerable inter-occupational tensions, especially where perceived overlap exists between the roles of HTs and those of other health occupations (see for example, Attree et al. 2012; South, Woodward, and Lowcock 2007). The literature on occupational boundaries and boundary-work is therefore germane to our study.

Boundaries and boundary-work

Gieryn (1983) is generally credited with coining the term 'boundary-work', originally employed to analyse the discursive practices by which scientists seek to attribute valorised qualities to scientists, scientific methods, and scientific claims, in order to draw a 'rhetorical boundary' around science, distinguishing it from other (purportedly) less authoritative 'non-science'. The concept of boundary work has subsequently been deployed in a variety of domains, including in various areas of inter-professional or inter-occupational jurisdiction, particularly where there exist hierarchical status and power relations between groups (Lamont and Molnár 2002). Within the literature on sports-, exercise- and health-related occupations, studies of boundary work include Theberge's (2008, 2009) analysis of professional boundaries in sport medicine, Malcolm and Scott's (2011) research on the professional relations among and between different healthcare providers within medicine and physiotherapy, and Scott and Malcolm's (2015) examination of the blurred boundary between health care and sports training in physiotherapists' work (Scott and Malcolm 2015), together with studies of the boundary work between various specialist groups involved in the treatment of musculo-skeletal injuries and problems (Norris 2001). In the wider medical context, boundary work between nurses and doctors (Allen 2001), nurses and nursing assistants (Dahle 2003), and between those tasked with caring for heart attack patients (Cramer et al. 2018), has been investigated. To date, however, there is scant research into such boundary work between HTs as 'lay' workers and the other health occupations with which they interact, both face-to-face, and also at a distance, in terms of client referral.

   In this article, we seek to advance knowledge in the field of health-related occupations, by investigating how HTs work at, manage, and communicate about professional/occupational boundaries in order to provide support to their clients in achieving and sustaining healthy behaviour change. We explore both the vocabularic and associative identifications made by HTs, together with their boundary work, all of which were identified as salient themes within the research study described below.

The research

The qualitative research project was approved by a UK university ethics committee. To encourage debate and discussion, both amongst HTs and with members of the research team, we selected focus groups as the most appropriate method. We sought participants' experiences and perceptions of the HT role, and how they both individually and collectively made sense of, and constructed meanings around their occupational identity and experiences. Providing a safe space to foster open and frank discussions was thus important, and we were careful to ensure that no managers were present, to avoid constraining discussions. The nature of the research was explained to interviewees, and we emphasized that no form of evaluation or reporting of findings to managers or others in the hierarchy would result. The group interviews were undertaken in a meeting room at a time when HTs were already on campus for scheduled in-post training (as part of the continuing professional development), thus avoiding the need to make separate journeys or time commitments. Some HTs already knew each other through their work, although to varying degrees, given that many worked primarily in a solo capacity. The group setting created a social space where participants appeared to interact freely and informally with each other, and also with the research team. Nevertheless, we are cognisant that, as in all interactional encounters, interviewees were engaged in particular presentations of self (Goffman 1959) as credible and professional HTs, both to us as researchers and to their HT colleagues as significant occupational others.

   Twenty-eight HTs (aged between 19 and 55) were invited to take part in the study, with 25 eventually agreeing to participate. Experience in the occupation ranged from between several months to seven years, with the mean years-in-service being 2.3. Four focus groups were conducted by trained coordinators on the research team. Group discussions were semi-structured so as to provide some consistency in issues raised and in particular questions, but also to allow participants to depart from researcher-generated questions, and to develop new topics and lines of discussion emergent in the interactional context. Questions posed were general, for example, regarding entry routes to the role, the areas of work covered and any particularly specialisms HTs had, opportunities for training and professional development, career structure, and the key challenges facing the HT service. All discussions were digitally recorded, and transcribed verbatim by Author 2. The transcripts were then analysed via inductive thematic analysis (TA), drawing on Braun and Clarke (2006) six-phase TA model, which involved 1) data immersion via multiple readings, to familiarise ourselves with the data 2) generation of initial codes 3) seeking general themes whereby research team members discussed preliminary codes, identified key themes and sub-themes, subsequently 4) reviewed and refined these themes/sub-themes, before 5) defining and labelling themes, and then 6) drafting the analysis and writing up. In terms of defining and labelling themes, sociologists on the team began to identify resonances with the literature on identity, identity work and boundary work in many of the participants' comments and so it was decided to use this literature to frame the findings and discussion. In the data extracts presented below, we have identified in which Focus Group (FG) the comments were made, and have anonymised participants by allocating individual numbers. We should emphasize that, in common with other research approaches that rely on the accounts of our participants, these accounts constitute our 'data', co-produced by participants and researchers in the specific interactional context of the research encounter (Allen-Collinson et al. 2018).

Results and discussion

The nature and perceived purpose of the HT role, HTs' occupational identity work, role boundaries and boundary work were identified as salient themes throughout all transcripts. These themes are explored under the identity work framework portrayed above. Commensurate with symbolic interactionist perspectives on identity construction and maintenance, such boundary work is often undertaken at the margins between occupational areas of jurisdiction, where groups seek to affirm differences and similarities between in-group members and out-group 'others'. Furthermore, as Cruz and Meisenbach (2018) portray, this process is an ongoing communicative one through which boundaries are negotiated, renegotiated, accepted and contested during everyday lived experiences. For the HTs studied, this ongoing, everyday boundary work appeared to be pursued primarily via vocabularic identification (identity talk) and associative (and disassociative) identification with other groups of workers, as we delineate below.

Interestingly, materialistic identification did not feature in the HTs' accounts, other than when one HT noted the difficulty in securing a private office in which to conduct meetings with clients. We have therefore chosen to 'follow' the data, and focus upon the elements of identity work that HTs reported as key to their roles.

Vocabularic identification: 'we talk'

As indicated above, Perinbanayagam's (2000) conceptualisation of vocabularic identification is akin to Snow and Anderson (1995) notion of verbal construction and assertion of personal identities, or, more prosaically, 'identity talk' (e.g. Allen-Collinson 2007; McDowell 2015). This form of identification focuses on how, as social actors, we project a particular identity during interactional encounters via verbal articulations of the sought identity, including using the vocabulary specific to that identity, for example, as a sociologist presenting a conference paper to an audience comprised of fellow sociologists. Drawing on Goffman's (1959) detailed insights into the presentation of self, Down and Reveley (2009), note how 'displaying' oneself in spoken interaction is central to identity formation in providing face-to-face confirmation of identity to others. In this regard, during the focus groups our participants engaged extensively in vocabularic identification as HTs; that is in undertaking: 'the verbal and expressive confirmation of one's acceptance of and attachment to the social identity associated with a general or specific role' (Snow and Anderson 1995, 245). With regard to defining and describing this role, however, many interviewees considered it to be ill-defined and at times all-encompassing. A gamut of different definitions and descriptions ensued in discussion, but health education and health promotion were identified as salient for many, who emphasized their focus upon motivating, encouraging, goal-setting, advising upon, and particularly *supporting* healthy lifestyle change, in a positive, practical, and non-judgemental mode:

> That's what we do, we try to encourage lifestyle changes. It's not something that they [clients] *have* to do. We have to get them to engage with us and get them to participate again [in physical activity] without them feeling like they are being forced to do it. FG1, HT2

> I think it is about giving them [the client] the practical tools, as well, so not just talking around things, it is actually about giving them something to focus on as well – a goal set or a tool that they can use. FG3, HT19

The nebulous and generic nature of the role, together with the wide range of health-related issues with which HTs had to contend, emerged strongly for many interviewees, making the specifics and boundaries of the role at times difficult to chart:

> Erm … everything from basic housing problems to mental health issues, domestic abuse, obesity, financial issues and sexual violence. Anything and everything isn't it? FG1, HT4

Interestingly, whilst such diversity could be deemed problematic for identity construction, in effect, this wide role remit served to generate understanding between participants of the distinctiveness of the HT role as having responsibility for dealing with such an extensive range of health issues, in contrast to other more 'specialised' or single-issue health occupations (see also Norris 2001).

A defining feature in HTs' identity talk involved being patient- or client-centred and, above all, being a 'people-person' able to relate well to others; a skill that training, qualifications and specialism did not necessarily capture or ensure, according to participants:

> Lots of different things really, people come in for different reasons so you take on board what that client needs. FG4, HT22

> Just because you have been in the role a long time doesn't necessarily mean that you know more and it doesn't really matter what qualifications you have got. If you can't sit down and talk to somebody and relate to them and make them feel comfortable and work with somebody, then you could know everything that you need to know about nutrition and fitness and whatever but if you can't relate to people then it doesn't make one bit of a difference. So training is really, really important because you need to know what you are on about, but you need to have life skills and be able to relate to people. FG2, HT12

This valorisation of patient/client-centredness, people skills and the ability to empathise coheres with wider health and medical research on occupational boundary work; for example, between theatre nurses and Operating Department Practitioners (ODPs), where nurses strongly emphasize their 'caring' role and abilities, and concern for the patient more holistically (Timmons and Tanner 2004; see also Lawler 1991). Here, a holistic approach, people skills and caring work, are contrasted with the technical training and technicist approach of other health workers. In terms of vocabularic identification, then, HTs' 'we talk' expressed how 'we' are different from 'them' (see also Norris 2001).

One of the key occupational identity challenges HTs reported with regard to social identities as construed by others, was the lack of knowledge about and understanding of their role by the general public and also by other health workers, including GPs. The very occupational nomenclature itself was seen as unhelpful and uninformative; several HTs reported they had not themselves been sure of the nature of the role prior to applying for the job, believing it to be more akin to that of a gym or fitness instructor:

> When I applied, because of the name, I completely overlooked it and thought it was just being a gym instructor and you know we have clients that think we are fitness instructors but we are more like healthy lifestyle advisors in a way. FG1 HT6

Furthermore, interviewees pointed out how the HT role had substantively changed over the years, and how it continued constantly to extend and evolve, rendering it difficult to define precise role parameters. Such development also required HTs to undergo further training and work in specialist areas they often regarded as outside of their jurisdiction, and for which they were not financially rewarded:

> We have to train more and do more stuff because the funding for other services is being cut and withdrawn, so it is like … oh I know let's just give that [job role] to the HTs. We don't get anything back, if you know what I mean, so we are doing more for nothing. I mean like when I started the job there was less work and now it is the same pay but more and more work. FG1, HT4

> You don't have a choice either, it is not that we are *choosing* to do more, we are being asked to do more because of the GP referrals. When they [GPs] are referring someone in with dietary needs and physical needs and mental needs, you can't dismiss it, and that is what they expect them to be helped with as well … FG3, HT20

HTs' occupational 'openness' to interpretation by the public, other health professions, and potential clients, was in many ways beneficial to clients, not generally requiring referral from a gatekeeper or specialist service. For the HTs themselves, however, this openness or vagueness of role was challenging in terms of occupational identity, development of a specialist area of work, and acknowledgement of their specific expertise and skills:

> It is good because we are not specialised in anything so anyone can come to us and they are guaranteed to be signposted somewhere or actually get our service. It is not good for us though, because we are not actually specialised in anything. FG1, HT5

In contrast to such narratives of non-specificity, however, certain distinctive occupational features were revealed through data analysis: two spatio-temporal elements, of 1) the community setting, and 2) time-intensive labour. Both these elements HTs indicated as fundamental in distinguishing them from other health and exercise occupations, particularly medical professionals and others working in clinical or 'formal' exercise settings. We thus next consider a further form of identification salient in the data: associative identification in Perinbanayagam's (2000) terms.

(Dis)associative identifications: place and time

Associative identification, or 'selective association with others' in Snow and Anderson's formulation (1995), refers to the ways in which social actors assert identities via choosing to associate with – and relatedly, to disassociate from – other social actors and groups, for example, with other athletes/performers participating at a similar level of the sport, but not with more 'casual' participants (Allen-Collinson and Hockey 2007). Similarly, Williams and colleagues (2018) portray how ex-military personnel continue to associate with other former service personnel, even when they have retired from active service. Most of the HTs in the current study associated with individuals and groups in their local communities; indeed, the importance of the local community setting and focus of their work were emphasized, together with the benefit, even necessity, of having detailed knowledge of, and sensitivity to, that local community. In this regard, HTs engaged in boundary work relating to associative and just as importantly, dis-associative, identification. This latter Snow and Anderson (1987) term associational distancing. Participants adhered strongly to a lay, community-based identity, differentiating and disassociating themselves and their area of work from what they perceived as highly formalized 'medical' and 'clinical' work and workers. These medical settings they construed as intimidating and 'off-putting' social spaces where many of their clients would never consider venturing:

> Within the area that we are based we are able to go out. There is a community service, there is the hub near the X road so there is other areas that we can actually go out to and we would be able to bring people in that wouldn't necessarily come into the GP surgery. FG4, HT23

> The fact that we work in the community so closely we do know where to signpost people [to other services], it's not just, I've got to give them a leaflet, it is knowing what the services are and how we can help them. FG2, HT9

> I have taken a client to get help with reducing alcohol to the DART[2] team. She said she wouldn't have gone if I hadn't have taken her. Then she went on her own after that … FG4, HT24

Again, the HTs engaged in discursive strategies that highlighted their client-centred, community-relevant, and holistic perspective, together with their approachability in places open to 'ordinary people', whilst contrasting these with more formal and intimidating medical settings.

With regard to the spatio-temporal dimension, and as also evident in the above extracts, in addition to their community place-embeddedness, HTs identified *time* as a pivotal feature distinguishing them from other health-related occupations, and enabling them to get to know in-depth individual clients and their lifeworld circumstances, and to support clients over the longer term. In their identity talk, HTs contrasted their own availability and flexibility of time with those of other health services and professionals, particularly time-constrained GPs, nurses and specialists:

> Having an hour with somebody on a one-to-one they will tell you what their problems are and we can work it out together, the health professionals haven't got that time to spend with people. FG2, HT11

> We know that GPs or nurses or mental health specialists don't have the time, they just need to move it on to the next person. FG3, HT18

The HT role was portrayed as distinctive, even 'unique' in being able to achieve healthy behaviour change because HTs had the time to get to know their clients, to understand and appreciate their lifeworlds, biographical and socio-economic contexts, and provide support over a relatively long time-frame, in a way that other 'clock-watching' health occupations simply could not:

> Because we understand the diabetes nurses and dieticians, they have a small window where they can see these people, whereas with the backup of a HT we can give them the information. We are not clinically trained, they [dieticians] are the specialists in their field to give that precise information but people need help to put into their everyday lives. They have to change to these foods that they have never eaten before and it is not just them, it is their family too, and we are there to help them do that. FG2, HT9

> … they quite like the fact that we have the time to listen to them. Because, you know, if they go to a GP they are in and out in 10 minutes, whereas they come to us and it is not just lifestyle advice. I find that a lot of my clients have got issues that have gone on in their childhood or as young adults that they have kind of kept to themselves and then they want to bring them up. Sometimes it is just a case of just listening and sometimes it is a case of asking if they have had any support with that, and maybe signpost them to different services that can help them. FG1, HT3

In the above extract, HT3 refers to her/his work as including what has been termed the 'soft skill' (Apesoa-Varano 2013) of listening, with the 'just' qualifier used linguistically by this HT to de-valorise or play down what appeared to constitute a large component of the HT role: according clients the time to talk and to be listened to by an empathetic and supportive other. As Apesoa-Varano (2013) notes, in many healthcare contexts, a discourse operates to reinforce an occupational hierarchy based on formal education and credentialing rather than on the knowledge derived from systematic, intimate, and often time-consuming social interaction with patients/clients. For HTs, it was having this time to devote to clients that constituted such a distinctive element in their strongly disassociative identification from other health occupations, particularly in bio-medicine. This valorisation of 'taking time' with clients/patients has also been identified as a notable feature of other health workers' boundary work, for example in nurses contrasting themselves to ODPs (Timmons and Tanner 2004). According to the HTs studied, 'having time' for clients allowed them to support them 'properly', 'step by step', thus facilitating lasting behaviour change, rather than abandoning clients to their own devices after quick, short-term interventions:

> We don't [just] tell them to lose the weight, like three stone in the next three months – we actually show them and we will take them through step by step. FG1, HT4

One of the reasons time was considered such so salient a component of HTs' identity work was that 'having time to talk' with clients meant they could delve deeper into people's circumstances and lifeworlds than could many other time-constrained and 'formal' health workers, according to interviewees. This could have important consequences in identifying what HTs perceived as the underlying causal factors lying behind the initial, ostensible presenting condition of a client, and thus in providing effective support for behaviour change; for example:

> Many years ago there was one lady that came in for weight loss, but when she was able to come in and sit down and had the time, because they [clients] don't have the time with the GPs or a lot of people, to talk through the underlying problems, you get to the root cause. Just by them talking, then the weight loss is not important, it is the wellbeing factor and a lot of that comes out when you have the time to talk to them. FG4, HT22

> You could get someone sent by the physiotherapist and then you could end up uncovering that they have serious mental health issues. It is the people that we don't expect to be like that. They come for one thing and then there is a whole host of other things … FG3, HT17

Delving deep to uncover underlying health and other issues was oft-reported as a crucial element of the HT role, but one that also generated concerns regarding boundary work and when/where to refer those clients assessed to have issues beyond the jurisdiction of the HT service, as is next addressed.

Maintaining the boundary: signposting to others

Despite the wide-ranging nature of their occupational role, most HTs reported being highly cognisant of their limits or role boundaries vis-à-vis other health workers, and how their role explicitly required respecting such boundaries and 'signposting' their clients on to specialist services when deemed necessary:

> I think that they [boundaries] are pretty clear and that we all know our limits and our role. We don't really go over our limits or our boundaries. FG2, HT11

> We do always say [to clients] that we are not medically trained and we can't go into depth with any of the medical issues … FG4, HT23

> It also goes back to boundaries as well, you know, if you feel like you are out of your depth but you stay within your boundaries then there is always a way through it. It is when you start overstepping that boundary then finding out that you are in the deep end. So it is about staying well within your boundaries. FG2, HT12

Sometimes, however, inter-occupational boundaries appeared more nebulous and permeable, requiring considerable interpretive work and active resistance to boundary-crossing activity, especially when HTs felt well-qualified to provide specialist advice and support, and might thus be tempted to work beyond-the-boundary. Participants then often hinted at frustration with having to remain within-boundary:

> Since other networks have come in we have got a lot more referrals from hospitals and mental health teams. I think that one of the biggest things for us is boundaries and staying within your boundaries because we are not supposed to do certain things and we are quite limited to what we can do. A lot of us have good knowledge and good skills to do more than we are supposed to. I know that we shouldn't go beyond our boundaries, especially with the counselling side of things, so it's just sitting and listening and just giving some advice. FG3, HT17

Whilst being role-obliged to refer clients on to other specialist services might be construed as disempowering, interestingly, the importance of effective referral and signposting work itself, and facilitating contact with other health workers was acknowledged by all participants as being *central* to their role, requiring knowledge of other appropriate specialist areas and how best to refer clients on:

> You are referring them as quick as you can because you have that connection direct to the service. Rather than being stuck on a waiting list you will probably know within a week at the most that they are going to be seen by whoever it is that you have referred them to. FG4, HT25

> We work quite closely with the GP referral team and usually for people if they come on to our books they work with every service and we will signpost them … Once I had a client who didn't want to do that [go to GP], and we started off with a programme that included walking and she ended up losing two stone and then she felt confident enough to go onto the exercise referral scheme and lost another two stone. FG3, HT19

HTs' identity work thus involved the recognition and valorisation of this referral aspect of their boundary work. In noting the importance of being able to refer clients on to the 'right places' (for example, exercise/physical activity referral schemes (ERS/PARS)), HTs also emphasized that without their signposting and facilitating work, clients might never know about a specific service, or feel able to take the steps to engage in exercise/physical activity programmes. They would thus remain outside or marginalised from such health improvement provision.

Summary and conclusion

The novel combination of two symbolic interactionist frameworks relating to identity work and boundary work respectively, was found to be fruitful in analysing the occupational experiences of HTs as reported to us in this qualitative study. Our intent here has been to investigate processes of identity work among HTs in order: 1) to understand the ways in which these workers seek to create and sustain credible identities that distinguish them from other health workers and thus give them

an identifiable occupational identity; 2) to contribute fresh empirical findings to theoretical perspectives on identity work and boundary work in health-related occupations, by focusing on the role of the HT (in the UK). We sought to advance empirical knowledge in the field of health occupations by investigating how HTs construct, work at, manage, and communicate about professional/occupational boundaries in order to provide targeted support to their clients in making – and, crucially, in sustaining – healthy behaviour change.

A salient finding was the identity work in which HTs engaged to 'work' the similarities with, and differences from, other health and exercise occupations. This coheres with symbolic interactionist conceptualisations of identity as strongly relational (Allen-Collinson 2006) vis-à-vis significant others. HTs thus identified the general goals, norms and values of health education and promotion they shared with other health workers, and their overlapping responsibilities and duties. They were, however, also vocal in emphasising the jurisdictional boundaries between their areas of work and responsibilities and those of other groups, such as GPs, psychologists, dieticians, and exercise professionals, such as fitness instructors. At times, they articulated clearly their belief in the firmness of these boundaries and their occupational responsibility not to 'overstep the mark' into the professional zones of others, even when this might generate personal frustration. Whilst much research has been undertaken on boundary work in formal healthcare settings such as hospitals and clinics (e.g. Timmons and Tanner 2004; Wicks 1998), there remain relatively few research accounts analytically grounded in boundary work undertaken in non-clinical healthcare settings, such as those occupied by HTs. This study thus contributes to a developing literature on boundary work and boundary management in non-clinical healthcare settings.

The findings resonate strongly with a wider research corpus, to provide analytic generalisability, which Smith (2018) highlights as important and appropriate to qualitative research. In the current case, analytic generalisability relates to wider organisational and structural processes in healthcare labour. The findings thus cohere with Apesoa-Varano's (2013) research on boundary work in hospitals, which can reinforce occupational cohesion and distinction at the institutional level, upholding an ideology of 'caring' while simultaneously denigrating such 'caring'. She points out how the emotional labour and 'soft skills' associated with emotive caring are rendered secondary to the esoteric knowledge and technical skills deemed central to medical work. Our findings indicate that such 'soft skills' constitute key and extensive components of HTs' work; labour that is indeed very time-consuming. The current research thus extends the sociological literature on health-based inter-professional boundary work (e.g. Allen 2001; Apesoa-Varano 2013) to the community setting, where HTs negotiate boundaries with other health professionals such as GPs, nurses, physiotherapists, exercise and fitness professionals, dieticians, and so on, whose professions/occupations often require esoteric knowledge, technical skills, and specific qualifications.

Whilst the time-consuming labour of 'deep' listening, working-with, helping and supporting clients sometimes over many months, may not be organisationally valorised as highly as esoteric knowledge and technical skills, it was this form of time-intensive work that was identified by HTs as so distinctive to their role. Also, and importantly with regard to achieving healthy behaviour change, it was this core element HTs construed as making a real and lasting difference in their clients' lives. According the time to listen to and talk with people meant that HTs felt they could delve deeper into clients' circumstances and lifeworlds than could many other more time-constrained health workers. This, they articulated, had important consequences for identifying problems, and in devising individualised programmes of healthy behaviour change custom-designed to be practicable for clients to achieve within the constraints of their socio-economic contexts and lifeworlds. Such in-depth engagement with client needs and the provision of individualised support have been identified as key to success in behaviour-change initiatives such as PARS (Vinson and Parker 2012).

Returning to the theoretical plane, micro-sociological theoretical perspectives such as symbolic interactionism have sometimes been critiqued for being astructural and neglectful of structural power relations. This, we argue, disregards important structural insights revealed by researching and analysing the micro-level. As Hughes, Hockey, and Greg Berry (2019) highlight, the power dimension is

important in interactional encounters as social actors compare themselves with others in order to gain a sense of how much power or competence they hold in relation to others. Such comparisons featured strongly in HTs' identity talk, as portrayed above. They also described in detail their active engagement in maintaining the boundaries they perceived between their area of jurisdiction and those of other more 'powerful', 'specialist' healthcare professionals. This boundary work can be theorised more generally at the meso level in that it appeared to leave unchallenged a status hierarchy within healthcare that privileges those trained and qualified in esoteric aspects of biomedical and exercise sciences and/or technical skills (see for example, Apesoa-Varano 2013). HTs often had to work long and hard at 'translating' knowledge and advice from such 'specialists' into practical support, to help clients achieve and sustain healthier behaviours. This was exemplified by the HT comments above in relation to dietary and nutritional advice given out by dieticians, where people often need considerable help in understanding and adhering to this advice in their everyday lives. Such sustained support work, whilst not accorded high status within the healthcare hierarchy generally, nevertheless may be vital in translating esoteric, scientific, bio-medical knowledge into public and community understanding, in order to achieve lasting healthy-behaviour change amongst those most at risk of, and from, unhealthy behaviour and health problems, particularly in disadvantaged communities.

Notes

1 Some Health Trainers are termed Health and Wellbeing Workers; we employ the generic term 'Health Trainer'.
2 Drug and Alcohol Recovery Team.

Disclosure statement

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